MEDI-CAL UPDATE Part 2
Billing and Policy
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Allied Health • Durable Medical Equipment

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Contents

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. Specific policy changes are detailed below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

DURABLE MEDICAL EQUIPMENT

Deleted Codes

HCPCS code A6551 (negative pressure wound therapy [NPWT] canister) has been deleted. All NPWT supplies must now be billed with revised code A6550 (negative pressure wound care set).

Codes E1019, E1021 and E1025 – E1027 (wheelchair accessories) have been deleted, and no replacement codes were created. Providers must use K0108 (other wheelchair accessories) to bill for these items.

Deleted and Replacement Codes

The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code	Replacement Code
E0972	E0705
K0064	E2213
K0066	E2220
K0067	E2211
K0068	E2212
K0074	E2214
K0075	E2219
K0076	E2221
K0078	E2215
K0102	E2207
K0104	E2208
K0106	E2209
K0452	E2210

Approved *Treatment Authorization Requests* (TARs) for deleted codes must be revised to the new codes if the date of service is on or after November 1, 2006.

Billing Restrictions

HCPCS codes A4604 (heated tubing), A9281 (grabbing device), and E2371, E2372 and K0733 (wheelchair batteries) may only be purchased, and must be billed with modifier -NU (new purchase). Labor for replacement of these items is not separately reimbursable. Claims for A4604 require prior authorization and must include documentation of patient-owned equipment in the *Reserved For Local Use* field (Box 19) of the claim.

Please see **HCPCS**, *page 2*

Billing Restrictions (continued)

Codes E0170 and E0171 (bathroom equipment) require prior authorization. Providers must document on the TAR that the patient has a neuromuscular dysfunction or disease, or arthropathy of the hips and/or knees.

Codes A4604, A9281, E0170, E0171, E0641, E0642, E0705, E0911 and E0912 are taxable items.

HCPCS codes E0471 and E0472 (Bi-PAP devices) may now be purchased. Maximum reimbursement is $6,164.88.

Codes E0637, E0638, E0641 and E0642 (sit-to-stand and standing frames) require prior authorization and must be rented for a minimum of three months before a purchase may be authorized.

Reimbursement for code E1031 (rollabout chair) includes all options and accessories. Accessory codes are not separately reimbursable with this code to any provider if billed within the same month of service.

Reimbursement for codes E1037 – E1039 (transport chairs) includes all options and accessories except codes E0995 (elevating leg rests, each) and K0195 (elevating leg rests, pair). No accessory code except those for elevating leg rests is separately reimbursable with codes E1037 – E1039 to any provider if billed within the same month of service.

Code E1392 (portable oxygen concentrator) is a rental-only code and must be billed with modifier -RR (rental). The reimbursement rate covers all accessories, including batteries.

New wheelchair accessory HCPCS codes E2210 – E2215 and E2220 – E2226 are not separately reimbursable to any provider if billed for the same month of service as manual wheelchair base codes E1161, E1229, E1231 – E1238, K0001 – K0007 and K0009.

Purchase Frequency Restrictions
Code A4604 is limited to one in six months.

Codes A9281, E0170, E0171, E0641, E0642, E0911 and E0912 are limited to one in three years.

Codes E0705, E2207 and K0734 – K0737 are limited to one in 12 months.

Codes E2208, E2209, E2215, E2371, E2372 and K0733 are limited to two in 12 months.

Codes E2211 – E2214 and E2218 – E2226 are limited to two in six months.

All of the above restrictions are for any provider.

ORTHOTICS AND PROSTHETICS

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code(s)	Replacement Code(s)
K0618 – K0619	L0491 – L0492
K0630 – K0649	L0621 – L0640
K0670	L5858
L0860	L0859
L3963	L3971, L3973
L8210	A6542
L8230	A6544

Purchase Frequency Restrictions
Code A6542 is limited to three pair or six individual stockings in six months, same provider.

Code A6544 is limited to two in six months, any provider.

Codes L0491, L0492 and L0859 are limited to one in six months, same provider.

Please see **HCPCS**, *page 3*

Purchase Frequency Restrictions (continued)

Codes L0621, L0623, L0625 – L0628, L0630, L0631, L0633, L0635, L0637, L0639 and L2387 are limited to two in 12 months, any provider.

Codes L0622, L0624, L0629, L0632, L0634, L0636, L0638 and L0640 are limited to two in three years, any provider.

Codes L2034, L3671 – L3673, L3702, L3763 – L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975 – L3978, L5703, L5858, L5971, L6621, L6677, L6883 – L6885 and L7400 – L7405 are limited to one in 12 months, same provider.

Billing Restrictions
Codes L2036 – L2038 (knee orthoses) are no longer reimbursable to podiatrists.

Codes L2034, L2387, L3671 – L3673, L3702, L3763 – L3766 and L3905 – L3976 may be billed as bilateral appliances.

A pair of orthotic shoes (i.e., two of single-shoe codes L3215 – L3217, L3219, L3221, L3222 and L3230) may be reimbursed on the same date of service, but claims must include a statement that at least one of the shoes is attached to a brace. The reimbursement rates for these codes have been revised due to the change in description from "pair" to "each."

Appliance addition codes will only be reimbursed when the base appliance has been provided. Addition codes may only be reimbursed separately if the item is being replaced or repaired.

Rate Revision for Orthotic Procedures
The reimbursement rate for code L2005 (knee orthosis) has been revised due to a correction to the Medicare rate.

The manual replacement pages reflecting these policies will be released in the October *Medi-Cal Update*.

HIPAA-Mandated HCBS Waiver Code and Policy Changes

Effective for dates of service on or after November 1, 2006, the Home and Community-Based Services (HCBS) waiver program will update billing codes from interim HCPCS codes to national HCPCS codes to streamline the billing process.

All existing waivers remain valid until the date of their expiration.

A total of 15 new waiver procedure codes will correlate with select modifiers and provider types in order to produce one reimbursement rate. All HCBS interim HCPCS codes starting with the letter "Z" will be replaced by the national codes.

The HCBS waivers administered by In-Home Operations (IHO) are restructured to reflect the medical facility alternative that the waiver serves.

- **In-Home Medical Care (IHMC) Waiver:** This waiver remains unchanged. It serves disabled recipients who, in the absence of waiver services, would otherwise require acute hospital services for at least 90 consecutive days.
- **Nursing Facility Subacute (NF-SA) Waiver:** This new waiver serves disabled recipients who, in the absence of waiver services, would otherwise require adult or pediatric subacute NF inpatient services for at least 180 consecutive days.
- **Nursing Facility Level A and B (NF-A/B) Waiver:** This waiver replaces the Nursing Facility (NF) Waiver. It serves disabled recipients who, in the absence of waiver services, would otherwise require NF-A (intermediate care) or NF-B (skilled nursing facility) services for at least 365 consecutive days.
- **Model-Nursing Facility Waiver:** This waiver was terminated. Recipients were transitioned to either the NF-SA or NF-A/B Waiver based on the recipient's facility alternative level of care.

Please see **HCBS**, *page 4*

DME Codes

Durable Medical Equipment (DME) providers may use the following HCPCS codes. All three codes are reimbursed with a negotiated rate specified on a *Treatment Authorization Request*.

Code	Definition (HCBS Usage)
S5160	Emergency response system; installation and testing. (Installation and testing of a Personal Emergency Response System [PERS] for individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who: live alone or who are alone for significant parts of the day; have no regular caregiver for extended periods of time; and who would otherwise require extensive routine supervision.)
S5161	Emergency response system, service fee, per month, excludes installation and testing. (Personal Emergency Response System [PERS] is an electronic device that enables individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who: live alone or who are alone for significant parts of the day; have no regular caregiver for extended periods of time; and who would otherwise require extensive routine supervision.)
S5165	Home modifications; per service. (Environmental accessibility adaptations that consist of physical adaptations to the home, given the individual's unique physical condition and requirements necessary to enable the waiver recipient to receive care at home and to ensure the health, welfare and safety of the individual. Lifetime benefit limit.)

Rental of Oxygen Stands

Effective for dates of service on or after October 1, 2006, HCPCS code E1355 (oxygen stand/rack) is reimbursable as a rental for up to three months, with prior authorization. Oxygen racks needed beyond three months are to be purchased. The monthly rental reimbursement for code E1355 is $4.36. *This information is updated on manual replacement pages dura 10 (Part 2) and dura cd 8 (Part 2).*

Medical Supply Products Updates

Effective for dates of service on or after September 1, 2006, the following diabetic supply products for Hypoguard USA have been added to the *Medical Supplies List* section:

Description	UPN	Bill Quantity in Total Number of
Haemolance Plus Micro Flow (28 gauge)	08317990250	Lancet
Haemolance Plus Micro Flow (28 gauge)	08317990200	Lancet
Haemolance Plus Low Flow (25 gauge)	08317990900	Lancet
Haemolance Plus Normal Flow (21 gauge)	08317990700	Lancet
Assure Pro Test Strips 50 ct.	08317460050	Strip
Assure Pro Test Strips 100 ct.	08317460100	Strip

Please see **Medical Supply**, *page 5*

Effective for dates of service on or after August 1, 2006, the following diabetic supply product for Abbott Laboratories Inc., MediSense Products has been added to the *Medical Supplies List*. Also, effective for dates of service after October 31, 2006, the following diabetic supply product has been end dated for Abbott Laboratories Inc., MediSense Products:

	Description	UPN	Bill Quantity in Total Number of
Add	Precision Xtra Beta Ketone	57599074501	Strip
Discontinue	Precision Xtra Beta Ketone	57599881508	Strip

These products are reimbursable to Pharmacy providers only, and must be billed using the Point of Service (POS) network, Computer Media Claims (CMC) or paper.

These updates are reflected on manual replacement pages mc sup lst1 15 and 18 (Part 2).

Billing Code Updates for Urological Products

Effective for dates of service on or after October 1, 2006, the following billing code updates shall apply:

- All billing codes with the Mentor manufacturer's Medi-Cal Code NR are no longer reimbursable, except for billing code 9943N. Coloplast Corporation purchased the Mentor Corporation urologicals division on June 2, 2006. However, billing code 9943N is still reimbursable with the manufacturer billing code NR. Therefore, the following billing codes with manufacturer's billing code NR are no longer reimbursable: 9912R, 9913P, 9913R, 9913S, 9913T, 9913W, 9914H, 9914I, 9914K, 9914L, 9914M, 9915Y, 9919J, 9919P, 9919S, 9919T, 9919W, 9919Y, 9959N, 9981E, 9981F, 9981H, 9981J, 9981K, 9981T, 9991K, 9991L, 9991M, 9992H, 9992J, 9992K, 9993E, 9993F, 9993H, 9993J, 9993N, 9993P, 9993R and 9999A.
- The following billing codes, with manufacturer's billing code MN, are no longer reimbursable: 9912R, 9912S, 9913J, 9913R, 9915Y, 9919J, 9959N and 9992H.
- All Sierra Laboratories, Inc. billing codes, with manufacturer's billing code YE, are no longer reimbursable. Those codes are 9991B, 9991D, 9991E, 9991F, 9994A and 9994B.
- The following billing codes, for products manufactured by Coloplast, are reimbursable with the manufacturer's billing code JN: 9912R, 9912S, 9913J, 9913R, 9913S, 9913T, 9913W, 9914F, 9914G, 9914H, 9914I, 9914J, 9914K, 9914L, 9914M, 9914N, 9914O, 9915Y, 9919J, 9919P, 9919S, 9919T, 9919W, 9919Y, 9959N, 9981D, 9981E, 9981F, 9981H, 9981J, 9981K, 9981T, 9992H, 9992J, 9992K, 9993N, 9993P and 9993R.

These updates are reflected on manual replacement pages mc sup lst4 3, 4, 5, 7, 17 thru 19 and 25 and mc sup man cd 6 and 7 (Part 2).

Adult Briefs Incontinence Supplies Addition

Effective for dates of service on or after July 1, 2006, providers can purchase three additional disposable incontinence briefs from Medline Industries at or below the Maximum Acquisition Cost (MAC) in the list on the following page. Reimbursement to providers for the following products begins for dates of service on or after July 1, 2006.

Manufacturers' products not included in a contract and not appearing in the provider manual are not Medi-Cal benefits, are not granted prior authorization with a *Treatment Authorization Request* (TAR) and are not reimbursable.

Please see **Adult Briefs**, *page 6*

Adult Briefs *(continued)*

Size	Description	Stock Number	UPN/UPC	Medi-Cal Guaranteed Acquisition and Maximum Allowable Cost	Billing Code
Youth	Protection Plus Classic Brief	MSC**95100	80196701446	$0.3064	9997Q
Small	Protection Plus Contour Brief	MSC**94250	80196762423	$0.3150	9997T
Small	Ultra Soft Brief	MSC**97250	80196735878	$0.3150	9997T

These updates are reflected on manual replacement pages *incont lst 3 and 4* (Part 2).

Primary Diagnosis Code Changes for GHPP Claims

Effective September 1, 2006, claims for reimbursement of Genetically Handicapped Persons Program (GHPP) services may be billed with a primary diagnosis code that reflects the condition for which the client seeks medical help. Previously, the primary diagnosis was limited to the ICD-9 code for the condition that qualified the client to participate in the Genetically Handicapped Persons Program.

For example, under the new policy if a client qualifies for GHPP due to cystic fibrosis (ICD-9 code 277.0) but presents to the doctor with the flu (ICD-9 code 487), then the code for the presenting condition would be entered as the primary diagnosis code. The code for cystic fibrosis would be entered as a secondary diagnosis.

This information is reflected on manual replacement pages genetic 5 and 6 (Part 2).

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71
238.72	238.73	238.74	238.75
238.76	238.79	277.30	277.31
277.39	284.01	284.09	284.1
284.2	288.00	288.01	288.02
288.03	288.04	288.09	288.4
288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64
288.65	288.69	289.53	289.83
323.01	323.02	323.41	323.42
323.51	323.52	323.61	323.62
323.63	323.71	323.72	323.81
323.82	331.83	333.71	333.72
333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19
338.21	338.22	338.28	338.29
338.3	338.4	341.20	341.21

Please see **ICD-9 Codes**, *page 7*

ICD-9 Codes *(continued)*

Additions (continued)

341.22	377.43	379.60	379.61
379.62	379.63	389.15	389.16
429.83	478.11	478.19	518.7
519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11
523.30	523.31	523.32	523.33
523.40	523.41	523.42	525.60
525.61	525.62	525.63	525.64
525.65	525.66	525.67	525.69
526.61	526.62	526.63	526.69
528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *
608.23 *	608.24 *	616.81 **	616.89 **
618.84 **	629.29 **	629.81 ** +	629.89 **
649.00 ** +	649.01 ** +	649.02 ** +	649.03 ** +
649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +
649.13 ** +	649.14 ** +	649.20 ** +	649.21 ** +
649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +
649.40 ** +	649.41 ** +	649.42 ** +	649.43 ** +
649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +
649.60 ** +	649.61 ** +	649.62 ** +	649.63 ** +
649.64 ** +	729.71	729.72	729.73
729.79	731.3	768.70 #	770.87 #
770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91
784.99	788.64	788.65	793.91
793.99	795.06 **	795.81	795.82
795.89	958.90	958.91	958.92
958.93	958.99	995.20	995.21
995.22	995.23	995.27	995.29
V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31
V58.32	V72.11	V72.19	V82.71
V82.79	V85.51	V85.52	V85.53
V85.54	V86.0 ** +	V86.1 ** +	

Restrictions

* Restricted to males only
** Restricted to females only
# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Please see **ICD-9 Codes**, *page 8*

ICD-9 Codes *(continued)*

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Instructions for Manual Replacement Pages — Part 2

September 2006

Durable Medical Equipment Bulletin 371

Remove and replace:

dura 9/10
dura cd 7/8
genetic 5/6
incont lst 3/4
mc sup lst1 15 thru 18
mc sup lst4 3 thru 8, 17 thru 20, 25/26
mc sup man cd 5 thru 8
ortho cd1 29/30 *
ortho cd2 21/22 *

* Pages updated due to ongoing provider manual revisions.